CHAPTER 8

Extension, Reduction, Suspension, Denial or Termination of Waiver Services

Any time a waiver service is denied, reduced, suspended, or terminated, the individual and/or legal guardian must be given written notice to include the details regarding the denial, reduction, suspension, or termination of service(s), allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination (when applicable).

It is a Federal requirement for the State to provide an opportunity for a fair hearing. According to Medicaid policy, the State (in this case, the DSN Board/Provider) must send written notice at least ten (10) calendar days before the date of action. The following reasons do not require a ten (10) calendar day notice before proceeding with the action:

- Denial of Waiver service,
- Client requested reduction,
- Loss of Medicaid eligibility,
- Voluntary withdrawal,
- Death,
- Individual moves out of state,
- Individual is admitted to an ICF/MR/Nursing Facility or Jail ,
- Individual moves to another HCB Waiver
- Individual cost limit has been reached.

If the individual or his/her legal guardian requests a hearing before the date of action, the State may not terminate, suspend or reduce services until a decision is rendered after the hearing. If the State's action is sustained by the hearing decision, the State may institute recovery procedures against the individual or his/her legal guardian to recoup the cost of any services furnished to the individual, to the extent they were furnished solely by reason of the appeal/reconsideration.

Extensions

The Community Supports Waiver includes an individual cost limit. This cost limit is the maximum dollar amount allocated to each waiver individual for a year (state fiscal year). Regardless of what happens during the year (including emergencies) it is expected that each individual receive authorized services that will not exceed the individual cost limit. For some individuals, however, unanticipated situations (i.e. crisis) will occur. When unanticipated changes happen, every effort must be made to respond to the changes within the confines of the cost limit. In the rare event that the person's needs, due to an unanticipated change, cannot be met within the confines of the cost limit, two options are available.

If an individual, due to an anticipated change in his/her condition or situation, has increased needs that will require the long term and ongoing authorization of services that exceed the cost limit, he/she will be referred to the Mental Retardation/Related Disabilities Waiver.

If an individual, due to an unanticipated, urgent change in his/her condition/situation, has increased needs that can be met by the short-term authorization of Community Supports Waiver services, an extension of the individual cost limit may be allowed. A short-term, unanticipated, urgent need (crisis) is defined as a situation in which the individual:

1) requires, on a short term basis, a service available through the Community Supports Waiver which if not provided will likely result in serious and imminent harm, **and**
2) has an immediate need for direct care or supervision due to a change in his/her condition **or**
3) has recently lost his/her primary caregiver and needs temporary care until further arrangements are made **or**
4) has a caregiver who is temporarily and unexpectedly hospitalized **or**
5) is ready for or has recently been discharged from a hospital and immediately needs services, on a short-term basis, to allow discharge or prevent readmission.

Extensions will not be approved for those individuals who exhausted their funding (up to the individual cost limit) prior to the next year's reallocation without a crisis situation identified and validated.

When the crisis situation is identified, a thorough explanation of the situation must be provided to the State Community Supports Waiver Coordinator for validation at the following address:

SC Department of Disabilities and Special Needs
Attention: Michelle Abney
3440 Harden Street Ext.
P.O. Box 4706
Columbia, South Carolina 29240

This explanation must include the nature of the unanticipated change; an explanation of why the change is urgent or creates a crisis (must correspond to reasons defined above); the services and amount of service authorized or to be authorized to address the crisis, the length of time anticipated before stabilization, and your email address and the email address of your Supervisor. All efforts to address the crisis within the confines of the cost limit must be explained thoroughly including the reasons why efforts were not successful. Any supporting documentation should be submitted.

Once received, the information will be reviewed to determine/validate that a crisis situation exists. You will be notified via email of the determination. This validation should be printed and placed in the individual's file. At the end of the fiscal/budget year, if services related to the crisis situation resulted in the individual cost limit being exceeded and the crisis situation has been validated, additional funds to cover the cost of those crisis response services provided can be requested.

Denials

If the individual and/or legal guardian requests a service(s) but it is denied (either at the local or state level), you are responsible for completing the **Notice of Denial (Community Supports Form 16-A)** within two (2) business days of denial of request is denied. The service or services that were denied should be indicated on the form along with the reason and comments to support that reason. If the service is currently being authorized through the Community Supports Waiver and the request was for additional units, the services will continue as authorized prior to the request. This should be explained to the individual and/or legal guardian in the comments. The original **Notice of Denial (Community Supports Form 16-A)** is sent to the individual and/or legal guardian along with the appeals process included on the back or attached. A copy should be placed in the individual's file.

Terminations

If an individual's service(s) are scheduled to be terminated, you are responsible for completing the **Notice of Termination of Service (Community Supports Form 16-B)**. The service(s) that are scheduled to be terminated should be indicated on the form along with the reason and comments to support that reason. The effective date for termination will be ten (10) calendar days from the date that the form is completed, which allows the individual ten (10) calendar days notice prior to termination of the service and the opportunity to appeal/request reconsideration that decision prior to termination (previous exceptions noted apply). If the individual appeals the decision within ten (10) calendar days of the notification, then the individual may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the individual will be liable for payment of those services. Nevertheless, the individual has a total of thirty (30) calendar days to appeal the decision; however, the service will be terminated if the service was not appealed within ten (10) calendar days. The original **Notice of Termination of Service (Community Supports Form 16-B)** is sent to the provider of the service. The individual and/or legal guardian will receive a copy along with the appeals process included on the back or attached, unless the individual and/or legal guardian requested the planned termination. A copy should be placed in the individual's file.

Please note: If the individual appeals within ten (10) calendar days, you must contact the provider of service and ensure that the service is uninterrupted.

Suspensions

During an individual's enrollment in the Community Supports Waiver, there may be circumstances when service(s) may need to be suspended, but not terminated. One such example would be when an individual is admitted to the hospital or nursing home and it is likely he/she may discharge within 30 days. In these instances, all waiver services must be suspended.

If an individual's service(s) are scheduled to be suspended, you are responsible for completing the **Notice of Suspension of Service (Community Supports Form 16-C)**. The service(s) that are scheduled to be suspended should be indicated on the form along with the reason and comments to support that reason. **If the individual has entered in the hospital or nursing home, then ten (10) calendar day notice is not required.** If the individual appeals the decision within 10 days of the notification, then the individual may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the individual will be liable for payment of those services. Nevertheless, the individual has a total of thirty (30) calendar days to appeal the decision; however, the service will be suspended if the service was not appealed with in ten (10) calendar days. The original **Notice of Suspension of Service (Community Supports Form 16-C)** is sent to the provider of the service. The individual and/or legal guardian will receive a copy along with the appeals process included on the back or attached. A copy should be placed in the individual's file.

Once the individual is ready to resume the service(s), you are required to submit a new authorization form to the chosen provider(s).

Please note: If the individual appeals within ten (10) days, you must contact the provider of service and ensure that the service is not suspended.

Reductions

If an individual's service(s) are scheduled to be reduced, you are responsible for completing the **Notice of Reduction of Service (Community Supports Form 16-D)** unless the planned reduction was requested by the individual/legal guardian. The service(s) that are scheduled to be reduced should be indicated on the form along with the reason and comments to support that reason. The effective date for termination will be ten (10) calendar days from the date that the form is completed, which allows the individual ten (10) calendar days notice prior to reduction of the service and the opportunity to appeal that decision prior to reduction (previous

exceptions noted apply). If the individual appeals the decision within 10 days of the notification, then the individual may choose to have the services uninterrupted while awaiting the outcome of the appeal. However, if the appeal is upheld, then the individual will be liable for payment of those services. Nevertheless, the individual has a total of thirty (30) calendar days to appeal the decision; however, the service will be reduced if the service was not appealed with in ten (10) calendar days. The original **Notice of Reduction of Service (Community Supports Form 16-D)** is sent to the provider of the service. The individual and/or legal guardian will receive a copy along with the appeals process included on the back or attached, unless the individual and/or legal guardian requested the planned termination. A copy should be placed in the individual's file.

Since there has been a change in the provision of the service, you are required to submit a new authorization form to the designated provider(s) with the reduction in service units authorized.

Please note: If the individual appeals within ten (10) calendar days, you must contact the provider of service and ensure that the service is not reduced.

If a request for appeal/reconsideration is received by SCDDSN Central Office, you will be notified immediately and receive instructions on how to proceed with the case.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

COMMUNITY SUPPORTS WAIVER

NOTICE OF DENIAL OF SERVICE

DATE:_____

TO:_____(Please check one): ☐ Individual ☐ Legal Guardian

ADDRESS:_____

_____

INDIVIDUAL:_____

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED. YOUR RIGHT TO APPEAL IS ATTACHED.

☐ Respite Services
☐ Adult Day Health Care
☐ Assistive Technology
☐ Day Activity
☐ Employment Services
☐ Career Preparation
☐ Community Services
☐ Support Center Services
☐ Personal Care Services
☐ Psychological Services
☐ In-Home Support Services
☐ Adult Day Health Care-Nursing
☐ Adult Day Health Care-Transportation
☐ Private Vehicle Modifications
☐ Environmental Modifications
☐ Behavior Support Services

Reason:

☐ Need(s) is/are not justified
☐ Service(s) is available through the state plan
☐ Exceeds individual cost limits
☐ Exceeds service limits
☐ Other_____

Comments (required for all reasons):_____

_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Individual/Legal Guardian Copy: File

APPEALS PROCESS IS ATTACHED

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disability (MR/RD) Waiver, the Community Supports (CSW) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER **---NOTICE OF TERMINATION OF SERVICE**

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Individual's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

<u>For SC/EI</u>: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, admission to an ICF/MR or NF, or exceeds the individual cost limit. This allows the individual 10 days notice prior to termination of service.

- ☐ Respite Services
- ☐ Adult Day Health Care
- ☐ Assistive Technology
- ☐ Day Activity
- ☐ Employment Services
- ☐ Career Preparation
- ☐ Community Services
- ☐ Support Center Services
- ☐ Personal Care Services
- ☐ Psychological Services
- ☐ In-Home Support Services
- ☐ Adult Day Health Care-Nursing
- ☐ Adult Day Health Care-Transportation
- ☐ Private Vehicle Modifications
- ☐ Environmental Modifications
- ☐ Behavior Support Services

<u>Reason:</u>

- ☐ Change in need no longer justifies original request
- ☐ Change in/no longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Other: _____
- ☐ Medical condition has improved
- ☐ Individual/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Individual moved out of state
- ☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days
- ☐ Exceeds individual cost limit

Comments (required for all reasons):_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Individual/Legal Guardian and File

COMMUNITY SUPPORTS Form 16-B

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disability (MR/RD) Waiver, the Community Supports (CSW) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

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The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

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SC Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

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Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
***COMMUNITY SUPPORTS WAIVER*--NOTICE OF SUSPENSION OF SERVICE**

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Individual's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of loss of Medicaid, admission to an ICF/MR, hospital or NF, or exceeds the individual cost limit. This allows the individual 10 days notice prior to suspension of the service.

- ☐ Respite Services
- ☐ Adult Day Health Care
- ☐ Assistive Technology
- ☐ Day Activity
- ☐ Employment Services
- ☐ Career Preparation
- ☐ Community Services
- ☐ Support Center Services
- ☐ Personal Care Services
- ☐ Psychological Services
- ☐ In-Home Support Services
- ☐ Adult Day Health Care-Nursing
- ☐ Adult Day Health Care-Transportation
- ☐ Private Vehicle Modifications
- ☐ Environmental Modifications
- ☐ Behavior Support Services

Reason:

- ☐ Medical condition has improved
- ☐ Change in provider availability
- ☐ Entered hospital/rehab (less than 30 calendar days)
- ☐ Entered nursing facility (less than 30 calendar days)
- ☐ Change in ICF/MR Level of Care
- ☐ Other_____
- ☐ Exceeds individual cost limit

Comments (required for all reasons):_____

_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address:_____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Individual/Legal Guardian and File

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disability (MR/RD) Waiver, the Community Supports (CSW) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

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Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
***COMMUNITY SUPPORTS WAIVER*-NOTICE OF REDUCTION OF SERVICE**

DATE FORM IS COMPLETED:_____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Individual's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/____MAY BE BILLED.

For SC/EI Only: the effective date is 10 calendar days from the date the form is completed with the exception of loss of Medicaid, admission to an ICF/MR, hospital or NF, or exceeds the individual cost limit. This allows the individual 10 days notice prior to suspension of the service.

- ☐ Respite Services
- ☐ Adult Day Health Care
- ☐ Assistive Technology
- ☐ Day Activity
- ☐ Employment Services
- ☐ Career Preparation
- ☐ Community Services
- ☐ Support Center Services
- ☐ Personal Care Services
- ☐ Psychological Services
- ☐ In-Home Support Services
- ☐ Adult Day Health Care-Nursing
- ☐ Adult Day Health Care-Transportation
- ☐ Private Vehicle Modifications
- ☐ Environmental Modifications
- ☐ Behavior Support Services

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in ICF/MR Level of Care
- ☐ Other_____
- ☐ Medical condition has improved
- ☐ Individual/legal guardian requested
- ☐ Exceeds individual cost limit

Comments(required for all reasons):_____

_____

Service Coordinator/Early Interventionist:_____

DSN Board/Provider:_____ Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Individual/Legal Guardian and File

COMMUNITY SUPPORTS Form 16-D

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

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A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

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SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.